6.a. Podiatrists' services:

- Podiatry services as provided by a podiatrist within the scope of practice defined in Minnesota Statutes, chapter 153 are covered services with the following limitations:

    1) Payment for the debridement or reduction of pathological toenails and of infected or eczematized corns or calluses is limited to once every 60 days.

    2) Payment for the debridement or reduction of nonpathological toenails and of noneczematized corns or calluses is limited to the following conditions:

        A) The recipient has a diagnosis of diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, or peripheral neuropathies involving the feet. The service is eligible for payment only once every 60 days unless the service is required more often to treat ulcerations or abscesses complicated by diabetes or vascular insufficiency and is medically necessary.
        B) The recipient who is not a resident of a long-term care facility has a medical condition that physically prevents him or her from reducing the nail, corn, or callus.

    3) A podiatry service provided to a recipient of a long-term care facility must result from a self referral or a referral by a registered nurse or a licensed practical nurse who is employed by the facility or the recipient's family, guardian, or attending physician.

- The following services are not eligible for payment:

    1) stock orthopedic shoes;
    2) surgical assistants;
    3) local anesthetics that are billed as a separate procedure;
    4) operating room facility charges;
    5) foot hygiene;
    6) use of skin creams to maintain skin tone;
    7) service not covered under Medicare, or service denied by Medicare as not medically necessary;
    8) debridement or reduction of the nails, corns, or calluses except as allowed above; and,
    9) general foot care that can be reasonably performed by nursing staff of long-term care facilities for recipients who reside in long-term care facilities.

6.b. Optometrists' services.

- Optometry services are covered if they are within the scope of practice for optometrists under State law or rule.

- The following eyeglass services are not eligible for payment:

  (1) Replacement of lenses or frames to change the style or color.
  (2) Cosmetic services. Examples are:
      (a) contact lenses prescribed for reasons other than aphakia;
      (b) keratoconus;
      (c) aniseikonia;
      (d) marked acuity improvement over correction with eyeglasses; and
      (e) bandage lenses.
  (3) Dispensing services related to a noncovered service.
  (4) Fashion tints and polarized lenses, unless medically necessary.
  (5) Protective coating for plastic lenses.
  (6) Edge and anti-reflective coating of lenses.
  (7) Industrial or sport eyeglasses, unless they are the recipient's only pair and necessary for vision correction.
  (8) Eyeglasses, lenses, or frames that are not medically necessary.
  (9) Invisible bifocals or progressive bifocals.
  (10) An eyeglass service for which a required prior authorization was not obtained.
  (11) Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement. The provider making the error is responsible for bearing the cost of correcting the error.
  (12) Services or materials that are considered to be experimental or nonclinically proven to prevailing community standards or customary practice.

6.b. Optometrists' services. (continued.)

(13) Eyeglass repair during the warranty period if the repair is covered by a warranty.
(14) Purchase of eyeglasses or lenses not covered by a contract obtained through the competitive bidding process.
(15) Backup eyeglasses.
(16) Photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromatism, cystinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.
(17) Transition lenses.
(18) High index plastic lenses.
(19) Eyeglasses or lenses for occupational or educational needs, unless they is the recipient's only pair and are necessary for vision correction.

6.c. Chiropractors' services.

- Coverage is limited to medically necessary manual manipulation of the spine for treatment of incomplete or partial dislocations and the x-rays that are needed to support a diagnosis of subluxation.

- Payment for manual manipulation of the spine of a recipient is limited to six manipulations per month and 24 manipulations per year unless prior authorization of a greater number of manipulations is obtained.

- ~~The following chiropractic services are not eligible for payment under medical assistance:~~

  ~~1) laboratory services;~~

  ~~2) diathermy;~~

  ~~3) vitamins;~~

  ~~4) ultrasound treatment;~~

  ~~5) treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation;~~

  ~~6) medical supplies or equipment supplied or prescribed by a chiropractor; and,~~

  ~~7) x-rays, except for radiological examinations of the spine, the cervical, thoracic, lumbar, and lumbosacral areas of the spine; the pelvis; and the sacroiliac joints.~~

6.d. Other practitioners' services.

A. **Mental health** services coverage is limited to those provided by the following ~~provider types~~ mental health professionals within the applicable scope of licensure: licensed psychologist, licensed psychological practitioner, community mental health center, licensed independent clinical social worker, masters prepared nurse with American Nurses Association certification as a clinical specialist in psychiatric or mental health, certified outpatient rehabilitation facility, and licensed marriage and family counselors in community mental health centers. For the purposes of this item, licensed marriage and family counselors provide only covered Medicaid mental health services such as family and individual therapy in multi disciplinary settings. Covered Medicaid mental health services does not include marriage counseling.

Mental health services are subject to the same limitations as psychiatric services described under Item 5.a., Physicians' services.

Community mental health center services means services provided by a facility that meets the requirements of Minnesota Statutes, §256B.0625, subdivision 5.

The community mental health center must be licensed under Minnesota Rules, parts 9520.0750 to 9520.0870 to provide mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level, or by a board-certified psychiatrist, or a psychiatrist who is eligible for board certification.

Community mental health center services are furnished by a private nonprofit corporation or a governmental agency and must have a community board of directors. Providers must be capable of providing the services to recipients who are diagnosed with both mental illness or emotional disturbance and chemical dependency, and to recipients dually diagnosed with a mental illness or emotional disturbance and mental retardation or a related condition.

6.d. Other practitioners' services. (continued.)

The following are included in the **community mental health center services** payment:

(1) Diagnostic assessment;
(2) Explanation of findings;
(3) Family, group and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management;
(4) Day treatment services; and
(5) Professional home-based mental health services.

The provider must provide 24-hour emergency care community mental health center services or demonstrate the capacity to assist recipients in need of such services on a 24-hour basis.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services** are limited to:

1) Nursing assessment and diagnostic testing;
2) Health promotion and counseling;
3) Nursing treatment;
4) Immunization;
5) Administration of injectable medications;
6) Medication management and the direct observation of the intake of drugs prescribed to treat tuberculosis;
7) Tuberculosis case management, which means:
   a) assessing an individual's need for medical services to treat tuberculosis;
   b) developing a care plan that addresses the needs identified in subitem a);
   c) assisting the individual in accessing medical services identified in the care plan; and
   d) monitoring the individual's compliance with the care plan to ensure completion of tuberculosis therapy; and
8) Personal care assessments, reassessments, and service updates. Assessments, reassessments, and service updates are conducted by county public health nurses or certified public health nurses under contract with the county.

   Such assessments must be conducted initially, for persons who have never had a public health nurse assessment. The initial assessment must include:

   a) a face-to-face health status assessment and determination of baseline need;
   b) collection of initial case data;
   c) identification of appropriate services and service plan development;
   d) coordination of initial services;
   e) referrals and follow-up to appropriate payers and community resources;
   f) completion of required reports;
   g) obtaining service authorization; and
   h) recipient education.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services.**

Reassessments are conducted, in person, at least annually or when there is a significant change in the recipient's condition and need for services. The reassessment includes:

a) a review of initial baseline data;
b) an evaluation of service outcomes;
c) a redetermination of need for service;
d) a modification of the service plan, if necessary, and appropriate referrals;
e) an update of the initial forms;
f) obtaining service authorization; and
g) ongoing recipient education.

Service updates are conducted in lieu of an annual face-to-face reassessment when a recipient's condition or need for personal care assistant services has not changed substantially, or between required assessments when the recipient or provider requests a temporary increase in services until an in-person review is conducted. The service update includes all the elements listed in ~~paragraph B.~~ items a) through g), above, but does not require an in-person visit.

If flexible use of personal care assistant hours is used, as part of the assessment, reassessment, and service plan development or modification, the recipient or responsible party must work with the public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan. This month-to-month plan must ensure that actual use of hours will be monitored and that the:

a) health and safety needs of the recipient will be met; and
b) total annual authorization will not be exceeded before the end date.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services.**

If the actual use of personal care assistant service varies significantly from the use projected in the service plan, the month-to-month plan must be promptly updated by the recipient or responsible party and the public health nurse.

Public health nurses who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d. Other practitioners' services. (continued)

C. **Ambulatory surgical center** means a facility licensed as an outpatient surgical center under Minnesota Rules, parts 4675.0100 to 4675.2800 and certified under 42 CFR 416, to provide surgical procedures which do not require overnight inpatient hospital care.

Ambulatory surgical center services covered under this item are facility services furnished in connection with a covered surgical procedure. The following items and services are included in the facility services payment:

(1) Nursing services and other related services of employees who are involved in the recipient's health care.
(2) Use by the recipient of the facilities of the ambulatory surgical center, including operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by those persons accompanying the recipient in connection with surgical procedures.
(3) Drugs, medical supplies, and equipment commonly furnished by the ambulatory surgical center in connection with surgical procedures. Drugs are limited to those which cannot be self-administered.
(4) Diagnostic or therapeutic items and services that are directly related to the provision of a surgical procedure.
(5) Administrative, record keeping, and housekeeping items and services necessary to run the ambulatory surgical center.
(6) Blood, blood plasma, and platelets.
(7) Anesthetics and any materials, whether disposable or reusable, necessary for the administration of the anesthetics.